

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$2,296.00 for dates of service 02/16/01 and extending through 02/28/01.
- b. The request was received on 02/14/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA(s)
 - c. TWCC 62 forms
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and Response to a Request for Dispute Resolution
 - b. TWCC-21 dated 03/22/01
 - c. TWCC 62 form
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/24/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 04/24/02. The response from the insurance carrier was received in the Division on 05/02/02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 04/19/02

“The supporting documentation provided substantiates the level of care given, the need for further treatments and indicates progress, improvement and the date of the patient’s next treatment. Our claim forms also indicated the services provided, length of service and our usual and customary charge for each date of service in dispute. Faxed copy of notification for initial 8 weeks of therapy/aquatic therapy treatment plan to adjuster...indicating that the patient has 2 weeks of therapy with...prior to our facility.”

2. Respondent:

“Regarding the charges denied with the rationale, ‘F-Rule 133.1 requires the submission of legible supporting documentation, therefore, reimbursement is denied.’

“It is this carrier’s position the requester is due NO additional reimbursement. The charges were denied because the requester did not provide the documentation required for the service.

The requester’s requests for reconsideration did not provide the necessary information. Exhibit 2.

It appears to be an error that the aquatic therapy for date of service 02/20/01 was denied with explanation codes F,T, and N when this bill was originally audited. It appears this service should have been denied with the explanation, ‘F-Rule 133.1 requires the submission of legible supporting documentation, therefore, reimbursement is denied.’

Regarding the charges with the rationale ‘F-T, N Documentation does not support the service billed. Carriers may not reimburse the service at another billing code’s value per rule 133.301(B). A revised CPT code or documentation to support the service may be submitted.’

Regarding Aquatic Therapy- It is this carrier’s position the requester DID NOT substantiate the medical necessity for or the occurrence of one to one therapy. For instance, the documentation provided by the requester for aquatic therapy does not support the medical necessity for one to one therapy for forward walking, backward walking, side to side walking. The question becomes, if the patient is unable to walk, how does he get to therapy.”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 02/16/01 and extending through 02/28/01.

2. COD1- T, F, N-“DOCUMENTATION DOES NOT SUPPORT THE SERVICE BILLED. CARRIERS MAY NOT REIMBURSE THE SERVICE AT ANOTHER BILLING CODE’S VALUE PER RULE 133.301 (B). REVISED CPT CODE OR DOCUMENTATION TO SUPPORT THE SERVICE MAY BE SUBMITTED.”
3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
02/16/01 02/19/01	97110	\$140.00 \$140.00	\$0.00 \$0.00	F,T,N COD1 F,T,N COD1	\$35.00/per (15 minute unit)	MFG;MGR (1)(A)(10)(a); (1)(A)(c) STG 134.1001 (e)(C); 134.1001 (g)(6)	<p>The Carrier denied the disputed services as: COD1 - T, F, N-“DOCUMENTATION DOES NOT SUPPORT THE SERVICE BILLED. CARRIERS MAY NOT REIMBURSE THE SERVICE AT ANOTHER BILLING CODE’S VALUE PER RULE 133.301 (B). REVISED CPT CODE OR DOCUMENTATION TO SUPPORT THE SERVICE MAY BE SUBMITTED.”</p> <p>F-“Reduction according to the Fee Guideline.” The provider billed CPT code 97110 in accordance with the Fee Guidelines. “Procedures (Supervision by the doctor or HCP, in either a group (97150) or one-to-one (97110-97139) setting is required.</p> <p>T-According to the referenced Rule, the claimant is entitled to ... “Post-tertiary treatment...Examples of interventions that might be utilized include office visits, manipulations, home exercises, injections, and medications.” Medical documentation indicates that the services were rendered.</p> <p>N-The SOAP notes reflected a diagnosis of shoulder and cervical strain. The notes are descriptive of modalities performed, length of procedures, and response from injured worker on how the therapy session helped the claimant. However, the SOAP notes do not support any clinical (mental or physical) reason as to why the patient could not have performed his exercises in a group setting, with supervision, as opposed to one-to-one therapy. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution Division indicate overall deficiencies in the adequacy of the documentation of this code. The disputes indicate confusion regarding what constitutes “one-on-one.”</p> <p>The Medical Review Division has reviewed the matters in light of all of the Commission requirements for proper documentation and concludes, there is insufficient documentation to allow reimbursement beyond one unit on each date of service.</p> <p>Therefore, the provider is due \$70.00 reimbursement.</p>

02/16/01	97124	\$140.00	\$28.00	F,T,N COD1	\$28.00 (each 15 minutes)	MFG;MGR (1)(A)(10)(a); (1)(A)(c) STG 134.1001 (e)(C); 134.1001 (g)(6)	<p>The Carrier denied the disputed services as: COD1 - T, F, N-“DOCUMENTATION DOES NOT SUPPORT THE SERVICE BILLED. CARRIERS MAY NOT REIMBURSE THE SERVICE AT ANOTHER BILLING CODE’S VALUE PER RULE 133.301 (B). REVISED CPT CODE OR DOCUMENTATION TO SUPPORT THE SERVICE MAY BE SUBMITTED.”</p> <p>F-“Reduction according to the Fee Guideline.” The provider billed CPT code 97110 in accordance with the Fee Guidelines. “Procedures (Supervision by the doctor or HCP, in either a group (97150) or one-to-one (97110-97139) setting is required.</p> <p>T-According to the referenced Rule, the claimant is entitled to ... “Post-tertiary treatment...Examples of interventions that might be utilized include office visits, manipulations, home exercises, injections, and medications.” Medical documentation indicates that the services were rendered.</p> <p>N-The SOAP notes reflected a diagnosis of shoulder and cervical strain. The notes are descriptive of modalities performed, length of procedures, and response from injured worker on how the therapy session helped the claimant. However, the SOAP notes do not support any clinical (mental or physical) reason as to why the patient could not have performed his exercises in a group setting, with supervision, as opposed to one-to-one therapy.</p> <p>Recent review of disputes involving CPT Code 97124 by the Medical Dispute Resolution Division indicate overall deficiencies in the adequacy of the documentation of this code. The disputes indicate confusion regarding what constitutes “one-on-one.”</p> <p>The Medical Review Division has reviewed the matters in light of all of the Commission requirements for proper documentation and concludes, there is insufficient documentation to allow reimbursement beyond one unit on each date of service.</p> <p>Since the provider was already reimbursed for the dates of service 02/16/01, 02/19/01, and 02/21/01 in the amounts of \$28.00 to \$56.00, \$28.00 from the date of service 02/21/01 will be applied for the date of service 02/26/01. The remaining dates of service 02/27/01 and 02/28/01 will be reimbursed at \$28.00 for each date of service.</p> <p>Therefore, the provider is due \$56.00 reimbursement.</p>
02/19/01		\$140.00	\$28.00	F,T,N COD1			
02/21/01		\$140.00	\$56.00	F,T,N COD1			
02/26/01		\$140.00	\$0.00	F,T,N COD1			
02/27/01		\$140.00	\$0.00	F,T,N COD1			
02/28/01		\$140.00	\$0.00	F,T,N COD1			

02/20/01	97113	\$224.00	\$0.00	F,T,N COD1	\$52.00 (each 15 minutes)	MFG;MGR (1)(A)(10)(a); (1)(A)(c) STG 134.1001 (e)(C); 134.1001 (g)(6)	The Carrier denied the disputed services as: COD1 - T, F, N-“DOCUMENTATION DOES NOT SUPPORT THE SERVICE BILLED. CARRIERS MAY NOT REIMBURSE THE SERVICE AT ANOTHER BILLING CODE’S VALUE PER RULE 133.301 (B). REVISED CPT CODE OR DOCUMENTATION TO SUPPORT THE SERVICE MAY BE SUBMITTED.”
02/21/01		\$224.00	\$0.00	F,T,N COD1			F-“Reduction according to the Fee Guideline.” The provider billed CPT code 97113 in accordance with the Fee Guidelines. “Procedures (Supervision by the doctor or HCP, in either a group (97150) or one-to-one (97110-97139) setting is required.
02/22/01		\$224.00	\$0.00	F,T,N COD1			T-A ccording to the referenced Rule, the claimant is entitled to ... “Post-tertiary treatment...Examples of interventions that might be utilized include office visits, manipulations, home exercises, injections, and medications.” Medical documentation indicates that the services were rendered.
02/23/01		\$224.00	\$0.00	F,T,N COD1			N-The SOAP notes reflected a diagnosis of shoulder and cervical strain. The notes are descriptive of modalities performed, length of procedures, and response from injured worker on how the therapy session helped the claimant. However, the SOAP notes do not support any clinical (mental or physical) reason as to why the patient could not have performed his exercises in a group setting, with supervision, as opposed to one-to-one therapy.
02/26/01		\$224.00	\$0.00	F,T,N COD1			Recent review of disputes involving CPT Code 97113 by the Medical Dispute Resolution Division indicate overall deficiencies in the adequacy of the documentation of this code. The disputes indicate confusion regarding what constitutes “one-on-one.” The Medical Review Division has reviewed the matters in light of all of the Commission requirements for proper documentation and concludes, there is insufficient documentation to allow reimbursement beyond one unit on each date of service.
02/27/01		\$224.00	\$0.00	F,T,N COD1			Therefore, the provider is due \$364.00 reimbursement. (7 dates of service x \$52.00= \$364.00.)
02/28/01		\$224.00	\$0.00	F,T,N COD1			
Totals		\$2,688.00	\$112.00				The Requestor is entitled to reimbursement in the amount of \$490.00 .

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$490.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 02nd day of October 2002.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division
MB/mb